

Fax: (807) 223-7063



HEARING CENTRES DRYDEN

40 Goodall St. Unit #2
Dryden, ON P8N 1V8
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Toll Free Fax: 1-877-923-7064

REFERRAL FOR:

Client Surname (Please Print): _____ Date Of Birth: _____

Client Given Name(s): _____

Address: _____

Client Phone Number: _____

PHYSICIAN INFORMATION

(Required for all patient referrals)

Physician Name (Please Print): _____

Physician / Nursing Station Phone #: _____ Fax #: _____

COVERAGE INFORMATION

(Complete if applicable)

Workplace Safety & Insurance Board _____ WSIB Claim #: _____

Department of Veterans Affairs _____ DVA Claim #: _____

Assisted Devices Program _____ ADP Claim #: _____

Treaty/Status _____ 10 Digit NIHB #: _____

Reason for referral:

